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| Case Number: | CM13-0056317 | | |
| Date Assigned: | 12/30/2013 | Date of Injury: | 06/03/2012 |
| Decision Date: | 03/19/2014 | UR Denial Date: | 10/31/2013 |
| Priority: | Standard | Application Received: | 11/22/2013 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and Emergency Medicine, and is licensed to practice in Florida. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This patient is a 53 year-old with a date of injury of 6/3/12. A progress report dated 10/16/13 identified subjective complaints of neck pain radiating into the left arm. Objective findings included normal sensation, motor strength, and reflexes of the upper and lower extremities. MRI has revealed cervical and lumbar disc protrusions. Diagnoses included lumbar disc disease, and cervical sprain/strain. Treatment has included physical therapy, chiropractic, injections, acupuncture and oral medications. The patient has been returned to modified work with restrictions of no standing more than 40 minutes per hour, no lifting greater than 20 pounds, and no repetitive bending.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

evaluation for a functional restoration program: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 30-33, 49.

Decision rationale: The MTUS Chronic Pain Guidelines state that there is strong evidence that intensive multidisciplinary rehabilitation with functional restoration reduces pain and improves

function of patients with low back pain. Such a program is considered medically necessary when all of the following criteria are met: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement, (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement, (3) The patient has a significant loss of ability to function independently resulting from the chronic pain, (4) The patient is not a candidate where surgery or other treatments would clearly be warranted, (5) The patient exhibits motivation to change, and (6) Negative predictors of success above have been addressed. In this case, the claimant does not meet all those criteria. Previous methods of treating pain have been unsuccessful. However, pain alone does not necessarily represent functional impairment. Baseline functional testing has not been established and physical findings that were described were normal. Likewise, there is no documentation as to whether the claimant has lost the ability to function independently due to the pain. She has been returned to modified work. Therefore, there is no documented medical necessity for a functional restoration program evaluation. The request is noncertified.